

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSF</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 W SECOND ST BLOOMINGTON, IN 47403</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Complaint number: IN00092487 Substantiated; no deficiencies related to allegations are cited</p> <p>Date of survey: 12-1-11</p> <p>Facility number: 005047</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Indiana University Health Bloomington Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules.</p> <p>QA: cloughlin 12/20/11</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1